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DEPARTMENT OF AUDITOR-CONTROLLER

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JOHN NAIMO
AUDITOR-CONTROLLER

February 4, 2016

TO: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: John Naimo
Auditor-Controller

SUBJECT: **DEPARTMENT OF HEALTH SERVICES – PHYSICIAN SERVICES FOR INDIGENTS PROGRAM CLAIMS ADJUDICATION SYSTEM REVIEW**

We reviewed the Department of Health Services' (DHS or Department) controls over the Claims Adjudication System (System) which is used to enroll participants and process medical claim payments for the Physician Services for Indigents Program (PSIP). Our review included testing to determine if key System controls and claim processing procedures are adequate to ensure that PSIP payments are accurate and authorized. We also reviewed the Department's procedures for submitting claims from the System to the electronic Countywide Accounting and Purchasing System (eCAPS) for payment, and procedures for monitoring PSIP claims processing accuracy and timeliness.

DHS developed PSIP in 1987 to reimburse non-County physicians and hospitals for emergency and trauma services provided to uninsured indigents, and operates PSIP from the Physicians Services (Maddy Fund) and Measure B Special Tax revenue funds. The funding sources include court fines and collections under Senate Bills 612 and 1733, and special taxes levied on improved property under County Measure B.

DHS contracts with a third party administrator, American Insurance Administrators (AIA), who developed the System and use it to process PSIP enrollment and claims. AIA staff enroll physicians in the PSIP program, and provide the physicians with access to submit electronic medical claims. Enrolled physicians can also send hard-copy PSIP claim forms to AIA that are then scanned by AIA into the System for review/approval. AIA transmits all approved PSIP claims to the Auditor-Controller, who loads the claims

into eCAPS for payment. During Fiscal Year 2014-15, DHS and AIA used the System to initiate payments for approximately 320,000 claims totaling $11.4 million.

Results of Review

We noted significant weaknesses in System controls for establishing vendors and processing PSIP medical claims for payment. Specifically:

- **Approval Controls** – DHS needs to require AIA to implement System approval controls for several key payment processing functions, as required by County Fiscal Manual (CFM) Section 8.9.1. We noted that AIA staff can change claim payment amounts without supervisory review/approval by modifying payment rates, units of service, and type of service. AIA staff can also override payment error messages and establish vendors in the System without supervisory review/approval. While we did not note any fraudulent vendors or payments, we identified overpayments to PSIP physicians, discussed below, that supervisory reviews may have been able to prevent.

  DHS' attached response indicates they will work with AIA to implement a supervisory review and approval of high value claim payments that are modified by AIA staff. Additionally, DHS will require AIA management to maintain records of payment override reviews. DHS' response also indicates they have implemented an independent review of vendor physician licenses to ensure they are valid and current prior to adding or modifying the vendor in eCAPS.

- **Payment Errors** – DHS needs to work with AIA to recover overpayments made to physicians, evaluate implementing System controls to exclude/reject claims that are incorrectly scanned into the System, and evaluate implementing System reasonableness checks to detect payment data entry errors. We reviewed 40 claims and noted two (5%) overpayments to physicians totaling $840. One error occurred because AIA staff scanned the claim into the System using the wrong type of medical service, and the System was not designed to detect the error and reject the claim. The other error occurred because an AIA claims examiner erroneously increased the units of service for the claim in the System from 2.5 units to 50, which increased the claim payment amount.

  DHS' attached response indicates they are working with AIA to recover one overpayment totaling $340 and instructed AIA to withhold the vendor's pending claim payments until receipt of the refund. DHS told us they recovered the second overpayment of $500 in October 2015.

  DHS' response also indicates they will evaluate the claims review process with AIA and implement a control that identifies the claim type at the beginning of the claims review process to ensure proper scanning. Additionally, DHS will work with AIA to

evaluate the feasibility of implementing reasonableness checks such as setting thresholds to alert AIA staff of possible errors, requiring supervisory review of claims that exceed certain thresholds, and prohibiting staff overrides.

- **Separation of Duties** – DHS needs to require AIA to separate the duties of establishing vendors and entering payments in the System, as required by CFM Section 8.4.1, or develop user activity reports to monitor users with these incompatible duties. We noted that three AIA managers have the ability to perform both functions in the System, increasing the risk that one person could attempt to establish and pay an unauthorized vendor. We could not determine if these users established and paid any vendors because AIA has not developed user activity reports.

  DHS' attached response indicates they will work with AIA to review the staffs' user access and separate incompatible duties.

- **System Interface** – DHS needs to resolve suspended payments in eCAPS and establish procedures to monitor suspense reports, as required by CFM Section 8.9.2. We found 312 PSIP payment requests for approximately $658,000 that remained suspended in eCAPS for up to four years until we reported the issue to DHS.

  DHS' attached response indicates they worked with AIA and resolved all the suspended payments noted in our review. Additionally, DHS indicates they implemented a procedure to immediately delete suspended payments in eCAPS.

- **DHS Program Monitoring** – DHS needs to ensure that staff periodically review PSIP physicians' patient medical records to verify the provision of the medical services claimed. We noted that DHS generally does a good job of monitoring physicians' compliance with PSIP program requirements. However, DHS staff do not review patient medical records to ensure that physicians did not submit erroneous or fraudulent claims.

  DHS' attached response indicates they will expand the scope of their PSIP physician reviews to include comparing PSIP medical claims to patient medical records to ensure medical services were accurately claimed and documented.

We also noted that DHS management needs to work with AIA to periodically review programmer changes to the System and payment rate tables, needs to evaluate the inclusion of relevant CFM policies in their claims processing contract with AIA, and needs to periodically monitor AIA's compliance with the policies. In addition, DHS needs to evaluate whether the recommendations in this report are applicable to other claims processing programs. Details of these findings and recommendations are included in Attachment I.

Review of Report

We discussed our report with DHS management. The Department's attached response (Attachment II) indicates general agreement with our findings and recommendations.

We thank DHS and AIA's management and staff for their cooperation and assistance during our review. If you have any questions, please contact me, or your staff may contact Robert Smythe at (213) 253-0100.

JN:AB:PH:RS:MP

Attachments

c: Sachi A. Hamai, Chief Executive Officer
Mitchell H. Katz, M.D., Director, Los Angeles County Health Agency
Public Information Office
Audit Committee

DEPARTMENT OF HEALTH SERVICES
PHYSICIAN SERVICES FOR INDIGENTS PROGRAM
CLAIMS ADJUDICATION SYSTEM REVIEW

Background

We reviewed the Department of Health Services' (DHS or Department) controls over the Claims Adjudication System (System) which is used to enroll participants and process medical claim payments for the Physician Services for Indigents Program (PSIP). DHS developed PSIP in 1987 to reimburse non-County physicians and hospitals for emergency and trauma services provided to uninsured indigents. DHS operates PSIP from the Physicians Services (Maddy Fund) and Measure B Special Tax revenue funds. The funding sources include court fines and collections under Senate Bills 612 and 1733, and special taxes levied on improved property under County Measure B.

DHS contracts with a third party administrator, American Insurance Administrators (AIA), who developed the System and use it to process PSIP enrollment and claims with very little DHS involvement. AIA staff enroll physicians in the PSIP program, and provide the physicians with access to submit electronic medical claims. Enrolled physicians can also send hard-copy PSIP claim forms to AIA, and AIA then scans the claim data into the System for review/approval. AIA transmits all approved PSIP claims to the Auditor-Controller, who loads the claims into the electronic Countywide Accounting and Purchasing System (eCAPS) for payment. During Fiscal Year (FY) 2014-15, DHS and AIA used the System to initiate payments for approximately 320,000 claims totaling $11.4 million, or an average of $36 per claim paid.

Payment Approvals

County Fiscal Manual (CFM) Section 8.9.1 requires transactions entered into information technology (IT) systems to be independently reviewed and approved before being submitted for processing. This helps to ensure transactions are accurate and authorized.

AIA's method of approving PSIP payments depends on whether the medical claim payment is for a "quick claim." AIA defines quick claims as claims for simple emergency medical services that are conducted in an emergency room setting and have fewer than five medical procedure codes. The System automatically reviews, approves, and calculates payments for all quick claims without the need for user involvement.

Non-quick claims include claims for more complex emergency medical services, such as for trauma, anesthesia, and multiple surgical procedures rendered in an emergency room or inpatient/outpatient setting. For non-quick claims, the System calculates payments but holds them for an AIA claims examiner to review and adjust the payment amount due to complexities in the claim approval and calculation process.

DHS Fiscal Services staff approves each batch of PSIP payments before AIA transmits them to eCAPS. However, DHS staff only approve that PSIP funding is available to cover the payments, and do not review the integrity of individual payments. To ensure the integrity of PSIP payments, DHS has specific monitoring controls in place to audit claim payments after they are issued, and to audit AIA's compliance with its claims processing contract. We discuss these controls in the DHS Program Monitoring section below.

Quick Claims

We noted that AIA does not require any supervisory review/approval for quick claims processed in the System and transferred to eCAPS for payment. Instead, AIA has developed automated System validations that perform the same functions as a supervisory review/approval. For example, the System validates that:

- Claims are from a valid PSIP provider;
- Medical procedure and diagnosis codes claimed are valid, reasonable, and qualify for reimbursement under PSIP guidelines;
- Claims are not duplicate based on the type of procedure, the date of service, and the patient;
- Required patient and claim information, such as patient name, patient date of birth, facility address, etc., are present and that information is consistent with reasonableness checks (e.g., patient date of birth cannot be after the service date, the facility must match the provider's enrollment, etc.); and
- Claims are submitted more than three months after the service date to allow adequate time to collect reimbursement from the patient or a third party medical coverage such as Medicare or Medi-Cal.

If a quick claim passes the validations, the System calculates payment amounts by referencing the medical procedure code from the claim to a payment rate stored in the System. The System then finalizes payments for transmission to eCAPS. While AIA indicated it would be costly and outside the scope of their contract to generate a report of all quick claim payments, we worked with AIA to estimate that they make up approximately 234,000 (73%) and $7.6 million (67% or $32 per claim paid) of all PSIP payments.

We discussed the System validations with AIA management, observed that a sample of validations functioned properly, tested nine quick claims, and noted that the automated validations generally ensure that claims are from a valid participant, are for valid PSIP services, include complete information, and are not duplicate. Therefore, it appears that AIA's automated quick claim validations generally compensate for the lack of a supervisory review/approval.

We did note that AIA scanned one (11%) of the nine claims reviewed into the System as a quick claim when it was actually a non-quick claim. The System validations did not detect this error and hold the claim for a claims examiner to review and adjust the

payment amount as required for non-quick claims. This error resulted in a $500 overpayment to the physician. Otherwise, we noted that the System accurately calculated the claim payments reviewed.

Based on the System validations, and the relatively small amount of the average quick claim payment, we do not recommend any changes to the quick claims review and approval process. However, DHS needs to work with AIA to modify the System to exclude/reject non-quick claims that are scanned as quick claims.

Recommendation

1. **Department of Health Services management work with American Insurance Administrators to modify the Claims Adjudication System to exclude/reject non-quick claims that are scanned into the System as quick claims.**

Non-Quick Claims

As mentioned, the System holds all non-quick claims for an AIA claims examiner to review. Claims examiners can review/adjust the payment amount for non-quick claims by modifying payment rates, units of service, and type of service, before finalizing the claim for payment. While AIA indicated it would be costly and outside the scope of their contract to generate a report of all non-quick claim payments, we worked with AIA to estimate that they make up approximately 86,000 (27%) and $3.8 million (33% or $44 per claim paid) of all PSIP payments.

We noted that there are no supervisory approvals required when an AIA claims examiner adjusts a non-quick claim payment amount in the System. We also noted one (3%) payment error in 31 non-quick claims reviewed that resulted in a $340 overpayment to the physician. The error occurred because the claims examiner accidentally modified the units of service paid on the claim from 2.5 to 50, which increased the overall payment amount to the physician. This error could have been prevented by a supervisory review/approval, and by System reasonableness checks to warn or prevent staff from modifying payment amounts or units of service by more than a pre-determined percentage or amount.

Recommendations

Department of Health Services management work with American Insurance Administrators to:

2. **Recover the overpayments noted in our review.**

3. **Implement supervisory approvals for claim payment amounts that staff adjust in the Claims Adjudication System.**

4. **Evaluate Claims Adjudication System reasonableness checks to warn or prevent staff from modifying payments or units of service by more than a pre-determined percentage or amount.**

Claim Overrides

When an AIA claims examiner has completed review of a non-quick claim and attempts to finalize the claim for payment, the System will alert the examiner if it determines that the claim is a possible duplicate or if the claim includes more than five medical procedures for the same patient on the same service date, which could violate PSIP guidelines. When examiners receive a System alert, they can override the alert and process the claim for payment, or reject the claim back to the participant.

We noted that claims examiners can override claim alerts without a supervisory review. While we did not note any inappropriate overrides in a sample of claims reviewed, a DHS internal audit conducted in June 2014 noted that AIA processed five inappropriate overrides during a five-month period for claims that should have been rejected back to the participant, resulting in $750 of duplicate payments.

In response to DHS' audit, AIA management developed reports for each of the two types of overrides processed in the System. AIA told us that supervisors review the reports weekly, before any payments are sent to eCAPS, to ensure that all overrides are valid. However, we could not verify that supervisors review the override reports before payments are issued because supervisors do not document their reviews.

Recommendation

5. **Department of Health Services management work with American Insurance Administrators to ensure that all payment overrides are reviewed by a supervisor and documented.**

Vendor Table Changes

AIA receives approximately 5,200 PSIP applications during each three-year PSIP enrollment period. AIA's enrollment staff verify that applicants (i.e., physicians) qualify for the PSIP program, enter them in the System's vendor table, and provide the vendors' W-9 tax forms to DHS Fiscal Services staff who establish the physicians in the eCAPS vendor table.

We noted that there are no approvals required when AIA enrollment staff modify the System vendor table. The lack of an approval control could allow AIA's enrollment staff to add an inappropriate vendor in the System, which allows the System to accept claims from that vendor. While DHS staff need to establish every vendor in the eCAPS vendor table before each can get paid, there is still a risk that AIA staff could try to establish an inappropriate vendor in the System and in eCAPS by submitting an erroneous W-9 form to DHS. Although DHS verifies that the taxpayer identification number on the W-9 form

exists in the Internal Revenue Services' database, they do not verify that the vendor is a valid physician who qualifies for the PSIP program.

We reviewed a sample of ten active PSIP vendors in the System and in eCAPS and noted that each was supported by enrollment documentation and had a valid physician's license.

Recommendation

6. **Department of Health Services management work with American Insurance Administrators to implement supervisory approvals for Claims Adjudication System vendor table changes.**

System Changes

CFM Section 8.6.0 requires system changes to be approved and tested before being implemented in production. It also requires management to periodically review system changes to ensure that programming staff comply with system change requirements. These controls help to ensure that system changes are authorized and operate as intended.

AIA management indicated that they have a process in place to authorize and test changes that their programmers make to the System (e.g., when programmers update payment rate tables, modify System programs that perform claim approvals, etc.). However, they also indicated that they do not periodically review all changes to ensure compliance with the testing and approval process. This increases the risk that AIA System programmers could bypass the approval and testing controls put in place to help prevent System errors.

While we noted no errors in a sample of payment rates tested and we observed that a sample of System validations functioned accurately, the lack of monitoring for System changes increases the risk of error and over/under payments. Payment rates and System validations are used to validate and calculate all PSIP payments totaling $11.4 million in FY 2014-15.

Recommendation

7. **Department of Health Services management work with American Insurance Administrators to implement periodic supervisory reviews for Claims Adjudication System changes.**

Separation of Duties

CFM Section 8.4.1 requires that no one person should be able to control all key aspects of a transaction. Individuals should not have incompatible processing functions, such as adding vendors and processing vendor payments.

We noted that AIA does not always separate the duties of establishing a vendor and entering payments in the System. Three AIA managers can perform both functions, increasing the risk that one person could attempt to establish and enter payment for an unauthorized vendor. We could not determine if these managers used their access to process any inappropriate vendors/claims because AIA indicated that creating a report of user activity would be costly, and is outside of the scope of work in their contract.

DHS should require AIA to separate the duties of establishing vendors and entering payments, or develop reports to monitor users with these incompatible duties.

Recommendation

8. Department of Health Services management require American Insurance Administrators to separate the duties of establishing vendors and entering payments, or develop reports to monitor users with these incompatible duties.

System Interface

AIA periodically generates an electronic file of claims processed in the System and transmits the file to eCAPS to pay PSIP providers. eCAPS will suspend payments received from the System if it detects errors, such as payments to a vendor who was deactivated in eCAPS. Suspended payments are listed on eCAPS exception reports until DHS corrects or cancels the payment. CFM Section 8.9.2 requires departments to monitor exception reports and resolve suspended items timely.

We reviewed the eCAPS Rejected Document Status Report and found 312 suspended payment requests for approximately $658,000[1] that came from the System. These payments remained suspended in eCAPS for up to four years. We reviewed 25 (8%) of the suspended payments and noted that AIA processed new payments to the physicians/hospitals timely because they have procedures in place to detect suspended payments in eCAPS and issue new ones. However, DHS Fiscal Services staff were not aware that they needed to remove the original suspended payment from eCAPS when the new payment is issued. This may increase the risk that the original suspended payments could get processed in duplicate.

DHS needs to resolve the suspended eCAPS payments noted in our review, including coordinating with AIA to ensure that each suspended payment was re-issued, and canceling the suspended payments in eCAPS to avoid processing them in error. DHS also needs to enhance their procedures to ensure that staff remove suspended payments from eCAPS in a timely manner.

[1] The per request average of $2,109 ($658,000 / 312) is higher than the overall average per claim of $36 because payment requests are often comprised of multiple claim payments to a single medical provider.

Recommendations

Department of Health Services management:

9. **Resolve the suspended payments noted in our review, including coordinating with American Insurance Administrators to ensure that each suspended payment was re-issued, and canceling the suspended payments in eCAPS.**

10. **Enhance procedures to ensure that staff remove suspended payments from eCAPS in a timely manner.**

DHS Program Monitoring

DHS has specific monitoring controls to ensure that AIA complies with its claims processing contract. Specifically, DHS' Fiscal Services periodically reviews a sample of AIA claims to determine if they were processed within contractually required timeframes, and performs data analytics to identify if AIA processed invalid claims, such as duplicates. Over the past two fiscal years, we noted that DHS Fiscal Services has made several recommendations to AIA to improve claims processing accuracy and timeliness.

In addition, DHS' Emergency Medical Services Agency (EMS) oversees PSIP participants (i.e., physicians) by periodically reviewing a sample of participants' accounting records to ensure they have only billed for eligible patients, have attempted to recover their cost of service through the patients' insurance before billing PSIP, and have reimbursed PSIP funds to DHS whenever they receive an outside insurance payment. We noted that EMS could improve its monitoring by reviewing PSIP participants' patient medical records to verify that medical services claimed were actually provided to patients and were accurately listed on the claim form.

Recommendation

11. **Department of Health Services management ensure that staff periodically review Physician Services for Indigents Program physicians' patient medical records to verify that medical services claimed were actually provided to patients and were accurately listed on the claim form.**

Claims Processing Contracts

Most of the control weaknesses noted in our review could have been prevented if DHS had included CFM IT control requirements in their contract with AIA and monitored for compliance. This includes CFM requirements for payment approvals and separation of duties. DHS also needs to establish a process to include relevant CFM policies in all future claims processing contracts.

In addition, DHS does not require AIA to provide the County with a Service Organization Controls 1 (SOC 1) report, as prescribed by the American Institute of Certified Public Accountants. SOC 1 reports provide an independent evaluation of a service organization's controls and how those controls impact the contracting entity's financial statements. DHS should evaluate the feasibility of requiring AIA to submit a SOC 1 report on an annual basis, developing procedures to review the SOC 1 reports, and working with AIA to mitigate any issues noted.

DHS also contracts claims processing services to AIA for two other programs; the Metrocare Physician Program and the My Health LA Program. Many of the recommendations noted for the PSIP program may apply to these other programs.

Recommendations

Department of Health Services management:

12. **Evaluate incorporating applicable County Fiscal Manual information technology control requirements in American Insurance Administrators' claims processing contract, and periodically monitor American Insurance Administrators' compliance with the policies.**

13. **Develop a process to ensure that County Fiscal Manual payment requirements are included in all future claims processing contracts.**

14. **Evaluate the feasibility of requiring American Insurance Administrators to submit a Service Organization Controls 1 report on an annual basis, developing procedures to review the reports, and working with American Insurance Administrators to mitigate any issues noted.**

15. **Evaluate if the recommendations in this report are relevant to other claims processing contracts with American Insurance Administrators.**

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

December 18, 2015

TO: John Naimo
Auditor-Controller

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **RESPONSE TO AUDITOR-CONTROLLER'S REVIEW OF DHS PHYSICIANS SERVICES FOR INDIGENTS PROGRAM (PSIP) CLAIMS ADJUDICATION SYSTEM REVIEW**

Attached is the Department of Health Services' response to recommendations made in the Auditor-Controller's report on the Physicians Services for Indigents Program Claims Adjudication System. We concur with and have taken or initiated corrective actions to address the recommendations contained in the report.

If you have any questions or require additional information, please let me know or your staff may contact Loretta Range at (213) 240-7755.

MHK:GP:lr

Attachment

c: Gregory C. Polk
Kay Fruhwirth
Manal Dudar
Johnny Wong
Loretta Range

www.dhs.lacounty.gov

COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES
RESPONSE TO AUDITOR-CONTROLLER DEPARTMENT OF HEALTH SERVICES (DHS) PHYSICIANS SERVICES FOR INDIGENTS PROGRAM (PSIP) CLAIMS ADJUDICATION SYSTEM REVIEW

AUDITOR-CONTROLLER RECOMMENDATION #1

DHS management work with American Insurance Administrators (AIA) to modify the Claims Adjudication Process/System to exclude/reject non-quick claims that are scanned into the System as quick claims.

DHS response:

We agree. DHS management will review the claims adjudication process with AIA and implement a control that identifies the claim type at the beginning of the adjudication process to ensure that non-quick claims are not scanned into the System as quick claims.

AUDITOR-CONTROLLER RECOMMENDATION #2

DHS management work with American Insurance Administration to recover the overpayments noted in our review.

DHS response:

We agree. DHS instructed AIA to notify the physician to refund the County the overpaid amount of $339.53 and withhold one of the physician's claim payments totaling $1,447.20 until receipt of the refund.

AUDITOR-CONTROLLER RECOMMENDATIONS #3 and #4

DHS management work with AIA to:

- Implement supervisory approvals for claim payment amounts that staff adjust in the Claims Adjudication System.

- Evaluate Claims Adjudication System reasonableness checks to warn or prevent staff from modifying payments or units of service by more than a pre-determined percentage or amount.

DHS response:

We agree. DHS will work with AIA to implement a supervisory review and approval of high value claim payments that have been adjusted by examiners. In addition, DHS will work with AIA to evaluate the feasibility of the following controls: setting thresholds to alert the examiner of possible errors, prohibiting examiner overrides, requiring a supervisor's review if a claim exceeds certain thresholds.

AUDITOR-CONTROLLER RECOMMENDATION #5

DHS management work with American Insurance Administrators to ensure that all payment overrides are reviewed by a supervisor and documented.

DHS response:

We agree. DHS will require AIA management to maintain records that evidences the supervisor's review of the payment override report. These records will be made available for DHS' inspection during the annual contract audit.

AUDITOR-CONTROLLER RECOMMENDATION #6

DHS management work with American Insurance Administrators to implement supervisory approvals for Claims Adjudication System vendor table changes.

DHS response:

We agree. DHS has implemented an independent check to verify that physician licenses are valid and current in the State Board's website prior to adding or updating the vendor in eCAPS.

AUDITOR-CONTROLLER RECOMMENDATION #7

DHS management work with AIA to implement periodic supervisory reviews for Claims Adjudication System changes.

DHS response:

We agree. DHS will work with AIA to implement a periodic review of system changes by the IT manager to ensure that changes affecting the County's program(s) have been authorized and approved. In addition, DHS will request AIA formalize and document

their policies and procedures regarding system changes to ensure compliance with County Fiscal Manual requirements.

AUDITOR-CONTROLLER RECOMMENDATION #8

DHS management require AIA to separate the duties of establishing vendors and entering payments, or develop reports to monitor users with these incompatible duties.

DHS response:

We agree. DHS will work with AIA to review the staff's user access and separate incompatible duties.

AUDITOR-CONTROLLER RECOMMENDATIONS #9 and #10

DHS management

- Resolve the suspended payments noted in our review, including coordinating with AIA to ensure that each suspended payment was re-issued, and canceling the suspended payments in eCAPS.

- Enhance procedures to ensure that staff removes suspended payments from eCAPS in a timely manner.

DHS response:

We agree. DHS worked with AIA and resolved all suspended payments from eCAPS that were noted in the review. New payments were processed and re-issued to the physicians. In addition, DHS implemented a procedure to immediately delete suspended payments in eCAPS when a payment request is rejected.

AUDITOR-CONTROLLER RECOMMENDATION #11

DHS management ensure that staff periodically review Physician Services for Indigents Program physicians' patient medical records to verify that medical services claimed were actually provided to patients and were accurately listed on the claim form.

DHS response:

We agree. DHS will expand the scope of the periodic review to include comparing submitted claim forms for medical services against patient medical records to ensure

medical services claimed were actually documented on patient medical records and accurately listed on claim forms.

AUDITOR-CONTROLLER RECOMMENDATIONS #12

Evaluate incorporating applicable County Fiscal Manual Information Technology control requirements in American Insurance Administrators' claims processing contract, and periodically monitor AIA's compliance with the policies.

DHS response:

We agree. DHS will review the County Fiscal Manual's (CFM) Information Technology control requirements to determine applicable CFM IT controls to be incorporated within AIA's claim processing system. In addition, DHS will perform periodic reviews of AIA's compliance with the policies.

AUDITOR-CONTROLLER RECOMMENDATIONS #13

Develop a process to ensure that County Fiscal Manual payment requirements are included in future claims processing contracts.

DHS response:

We agree. DHS will work with AIA to develop a process to ensure that CFM payment requirements are incorporated within AIA's claims processing policies and procedures.

AUDITOR-CONTROLLER RECOMMENDATIONS #14

Evaluate the feasibility of requiring American Insurance Administrators to submit a Service Organization Controls 1 report on an annual basis, developing procedures to review the reports, and working with AIA to mitigate any issues noted.

DHS response:

We agree. DHS will evaluate the feasibility of requiring AIA to submit a Service Organization Controls 1 (SOC1) report. If SOC1 reporting requirements are determined to be feasible, DHS will develop procedures to review them and work with AIA to mitigate any issues noted.

AUDITOR-CONTROLLER RECOMMENDATIONS #15

Evaluate if the recommendations in this report are relevant to other claims processing contracts with American Insurance Administrators.

DHS response:

We agree. DHS will review and evaluate the relevance of Auditor Controller recommendations noted in this report with other AIA claims processing contracts.